Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:	M4-09-B186-01
	DWC Claim #:	
	Injured Employee:	
	Date of Injury:	
Respondent Name and Box #: TASB RISK MGMT FUND REP. BOX #: 47	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "I am trying to recover $179.58 for TASB for an MRI that my physician requested. The attached correspondence details the facts of this case. It basically can be summed up in that TASB either lost paperwork or failed to follow-up. A written request for review was sent in time to TASB and the U.S. Post Office verifies that it was received in time."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $179.58
3. Itemized Statement

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The claimant is requesting reimbursement for his co-pay and or deductible/coinsurance for a bill that was never submitted to the TASB RMF. Therefore there can be no fee dispute. The request for an MRI was denied on preauthorization on January 20, 2009 stating that a peer to peer was done and the patient does not have progressive neurological deficit and therefore does not meet medical necessity criteria and failed to meet the Official Disability Guidelines (ODG)…The patient told the radiology company to bill his private insurance and not the workers compensation carrier… The fund feels that the MDR request has been submitted in the wrong venue since no bill was ever received. The fund feels this is a preauthorization dispute and the claimant failed to follow the guidelines for filing disputes…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
01/26/09	Out-of-Pocket expenses - MRI	1, 2	$0.00
Total:			$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 133.270, titled *Injured Employee Reimbursement for Health Care Paid, effective 05/03/06* set out the reimbursement guidelines.

1. According to the Respondent, a preauthorization request for an MRI was submitted by the claimants treating physician. On January 20, 2009 a request for the repeat lumbar MRI was denied. No information was submitted by the claimant as to whether or not an appeal of the carrier denial was made. The claimant did submit a U.S. Postal Service Track and Confirm report that shows an item was sent on January 29, 2009 and was delivered at 1:06 pm in Austin, TX; however, the Track and Confirm results did not show to whom the item was sent, nor is there an explanation of what was sent.
2. According to 28 TAC Section 134.600(o)(1) if the initial response to the request for preauthorization, the claimant or the claimant's treating physician may request reconsideration within 15 working days of the receipt of the written initial denial. The claimant's letter of January 28, 2009 to the carrier appealing the denial of preauthorization for the MRI was not made within the 15 working days as required.
3. In accordance with 28 TAC Section 133.307(e)(3)(D) the claimant has not submitted a copy of the carrier's denial of reimbursement or refund relevant to the dispute or convincing evidence of the claimant's attempt to obtain reimbursement or refund from the carrier.
4. Therefore, for the above reasons reimbursement cannot be ordered.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section. 134.1, 134.600, 133.307, 133.270
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor III Medical Fee Dispute Resolution	October 20, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.